

<b>Case Number:</b>	CM15-0052353		
<b>Date Assigned:</b>	03/25/2015	<b>Date of Injury:</b>	07/25/2001
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/19/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 58-year-old male, with a reported date of injury of 07/25/2001. The diagnoses include lumbar degenerative disc disease, L4-5 and L5-S1 bilateral foraminal stenosis, cervical postlaminectomy syndrome, status post cervical discectomy and fusion, right upper extremity radicular symptoms, and lumbar spine sprain/strain with multi-level spondylolysis / retrolisthesis. Treatments to date have included x-rays of the lumbar spine, x-rays of the cervical spine, an MRI of the lumbar spine, an anterior cervical discectomy and fusion with redo, and oral medications. The progress report dated 02/25/2015 indicates that the injured worker complained of increasing pain in his low back and right leg. It was noted that he was having significant difficulty with walking, and also had severe right shoulder pain. The injured worker stated that his weakness had increased over the last month. He had difficulty with walking and stating, continued to have numbness and tingling, and described a hot, burning, and electrical pain. The injured worker rated his pain 6-7 out of 10 with use of medications, and 9-10 out of 10 without medications. The physical examination showed right-sided cervical paraspinal tenderness with muscle spasms; global weakness in the right upper extremity; tingling in the right C6 and C7 dermatomes; bilateral lumbar paraspinal tenderness from L4-S1; positive straight leg raise test bilaterally; and decreased sensory in the lower extremities in the L4, L5, and S1 dermatomes. The treating physician requested a power wheelchair. It was noted that the injured worker had extreme weakness in his lower extremities and difficulty with his right upper extremity.

## IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Power wheel chair:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Powered Mobility Devices.

**Decision rationale:** The chronic pain guidelines state the following regarding motorized wheel chairs: "Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care." Additionally, ODG comments on motorized wheelchairs and says the following: "Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. (CMS, 2006) Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care." The treating physician documents that the patient cannot operate a manual wheel chair, cane is not sufficient, the patient has a right upper extremity deficit, and has no caregiver. As such, the request for Power wheel chair is medically necessary.